Revista Infoacceso
e-ISSN 2311-7605 (Online)
infoacceso.org/index.php/ri

Volume 13 · Issue 3 · 2026
Pages 3663–3668

Depression Among Older Adults: Distinctive Clinical Manifestations A Field Study at a Residential Care Center for Older Adults in Oran Province, Algeria

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Received: 23/06/2026 | **Accepted:** 26/10/2026 | **Published:** 17/11/2026

***Abstract*—**Old age is one of the essential stages of human life. It is a natural result of advancing age. This stage involves continuous, gradual changes in different aspects of life. These changes may be physical, social, psychological, or cognitive. They are not limited to biological aspects. Older adults may also face psychological challenges, including reduced independence and feelings of loneliness. These experiences vary according to psychological and social circumstances and the level of support a person perceives. Against this background, the present study aims to identify the level of depression among older adults and the main clinical manifestations of depression. A descriptive approach was adopted. The clinical scale for measuring depression developed by Nabil Mohamed El-Fahl (2016) was administered to a purposive sample of 30 older adults experiencing depression. The data were analyzed using appropriate statistical methods. The findings indicated a high level of depression among the older adults. Psychological disturbance ranked first among the clinical manifestations. Self-criticism ranked second, followed by pessimism, guilt, and sexual disturbance. The feeling of exhaustion ranked last. No statistically significant differences in depression levels were found according to age. Finally, a set of scientific and practical recommendations was included.

***Keywords*—**Depression; Aging; Clinical Manifestations; Older Adults.

Research Problem

Aging is a complex process. It involves physiological decline across the body, including the brain. Memory capacity may decrease, and thought and movement may slow. Other changes can also affect sensorimotor functioning.

Aging also affects the psychological life of older adults. This includes their emotions, dreams, thoughts, cognitive abilities, behavior, and inner imaginative life.

Aging should therefore be examined from a comprehensive perspective. This requires attention to the individual's relationship with the body, biological and physical disorders and capacities, and personality and its history. Relationships with the surrounding environment also matter, as does the ability to adapt to it. This assessment includes the positive or negative value attributed to the older person. Later life is often marked by negative events. These include loss, bereavement, separation, withdrawal from professional life, and issues relating to quality of life. Such factors may increase isolation and contribute to psychological disorders.

Depression is one of the common disorders of old age for several of the reasons mentioned above. Depressive manifestations and their accompanying clinical features, however, have distinctive characteristics in later life. These characteristics reflect the developmental features of this stage. It is therefore appropriate to consider the psychopathology of older adults.

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The present study therefore seeks to identify depression levels among older adults. It addresses the following questions:

- What are the distinctive clinical features of depressive manifestations in older adults from a psychodynamic clinical and psychopathological perspective?
- What is the level of depression among older adults, as measured by the clinical depression scale developed by Nabil Mohamed El-Fahl?

Study Hypotheses

Based on the research problem, the study hypotheses are formulated as follows:

- Both research questions are exploratory and therefore do not require hypotheses.

2. Theoretical Framework

1.1.2. Definition of Depression

Depression refers to a state of pathological sadness. The associated suffering is excessive in both intensity and duration. Its relationship with ordinary life events may be unclear, and it differs from usual responses to sadness. Depression may involve a loss of normal emotional responsiveness and disabling psychomotor slowing. Emotional and instinctual functioning is central to the disorder. Feelings of guilt may also be present (Granger et al., 2010, p. 77).

According to the DSM-IV, a major depressive disorder is characterized by the presence of at least five of nine clinical symptoms for a period of no less than two weeks. The clinical manifestations include:

- Depressed mood.
- Loss of desire or pleasure.
- Weight loss or weight gain.
- Insomnia or hypersomnia.
- Psychomotor agitation or retardation.
- Fatigue, feelings of guilt, or self-devaluation.
- Reduced desire to think or concentrate, and suicidal thoughts.

Assessing these symptoms in older adults is not always straightforward. Depression may be less apparent in this age group. It can present through physical complaints, including headaches, gastrointestinal disturbances, sleep problems, and loss of appetite.

Some symptoms resemble signs associated with ordinary aging. Others occur alongside cognitive difficulties or medical conditions. Sleep disturbances are one example (Jean, pp. 26–27).

Psychomotor disturbances, together with depressed mood, are among the central symptoms of depression. They appear at both motor and cognitive levels and affect behavior and mental processes. The DSM-5 includes psychomotor retardation and agitation among the nine clinical symptoms associated with major depressive disorder (Eric Pierre, 2016, p. 207).

Depression may have a protective value or function when it serves as a defense against more serious psychological disorders, such as schizophrenia or melancholia. In such cases, the person acquires a new level of psychological functioning and another sense of self (Michel, 2010, p. 22).

The semiology of a clear and fully developed depressive syndrome is characterized by three groups of symptoms: depressed mood, psychomotor slowing, and associated somatic signs. Depressed mood is persistent and is the main feature of depression. It involves involuntary pathological sadness, psychological pain, and pessimism toward oneself and the outside world. Loss of self-esteem and self-devaluation may also occur.

Depressed mood develops gradually and may be expressed through excessive negative emotional reactions in daily situations. This mood may be accompanied by episodes of uncontrollable crying, boredom, emotional indifference, and a loss of pleasure in usual activities. The depressed person may also experience a loss of the ability to move (emotional anesthesia). Feelings of guilt toward close relatives may be present (Michel, 2010, p. 26). The person experiences the present as painful and may be unable to plan for the future. The possible presence of suicidal thoughts should therefore be investigated.

Definition of Older Adults and Aging

Definitions of old age vary. It may be viewed as a natural change in human life and a stage of physiological development, like infancy, childhood, puberty, and middle age. Other definitions view aging as the cumulative result of several processes. Some are pathological, such as chronic diseases. Others involve physical, psychological, emotional, and related changes.

Views also differ on when aging begins. Some studies suggest that age-related physical, psychological, and cognitive changes may appear at different points in the life course. Aging is therefore often defined as the stage when physical and mental functions decline more visibly than they did in earlier years (Al-Zubaidi, 2009, pp. 19–20). Distinctions remain between chronological, biological, and psychological age.

- Chronological age: This approach considers 60 years the beginning of old age. The stage continues until the end of life and is often described as the third age. It is regarded as a natural period of human life.
- Biological age: This refers to gradual biological changes associated with cellular aging.
- Psychological age: This dimension includes psychological and mental difficulties, as well as social and economic changes. It may involve reduced activity and interests, declining abilities, and retirement. The following classification of older age is attributed to the World Health Organization:
- Adult (60–74 years): A person who continues to participate in life with energy and vitality.
- Elderly person (75–85 years): A person whose level of participation has decreased.
- Very old person (85 years and above): A person who is often bedridden.
- Centenarian (100 years and above) (Al-Zubaidi, 2009, pp. 20–22).

Old age may thus be defined in terms of people who have passed the age of 60 and who are no longer able to carry out activities with the same energy and vitality.

Some psychologists describe old age as a distinct developmental stage with specific psychological characteristics. These include a reduction in the capacity for psychological and social adjustment. The individual may find it harder to use physical and mental resources to cope with life demands.

Depression in Later Life

Abdullah (1999) indicates that old age involves many physical, health-related, social, and economic changes. These have a direct and fundamental effect on the older person's psychological state. Because older adults face different problems, they may experience psychological disorders such as anxiety, fear, and depression (Al-Sabbati & Raslan, 2008, p. 91).

Affective disorders are among the significant mental health problems experienced in later life. The following forms of depressive disturbance are identified:

- Mild mood disturbances.
- Neurotic and reactive depression.
- Severe depression.

El-Fahl (1990) describes depression as a common problem among older adults. Severe depression is reported to be less common than depressive symptoms. Depression in later life is also linked in this account to psychotic and affective disorders, and its severity is said to increase with age. Moussa (1993) identifies social withdrawal, tension, distress, and loss of appetite as important symptoms. Appetite loss may become so severe that the person refuses food, with consequences for general health. Other symptoms include physical discomfort, slowed movement, and reduced sexual desire. Older adults may become preoccupied with bodily functions and experience fear or health anxiety. They may also report worthlessness, insufficient or interrupted sleep, poor personal hygiene, difficulty concentrating, and guilt (Al-Sabbati & Raslan, 2008, pp. 92–93).

Distinctive Clinical Features of Depression in Older Adults

In clinical psychiatry, depression has several meanings. In adults, as in older adults, it may take the form of depressive complaints, loss of desire or pleasure, sadness, and feelings of emptiness. These experiences may be accompanied by automatic, negative, and irrational thoughts, including self-devaluation, guilt, and pessimism. The characteristic clinical syndrome includes depressed mood and marked somatic, motor, and cognitive symptoms. The broader context, co-occurring disorders, symptom severity, and the course of their development must be considered. Some symptoms are less common in adults than in older adults (Michel, 2010, p. 38).

3. Empirical Framework

Study design: A descriptive approach was used because it was considered appropriate for the aims of the study. This approach seeks to describe the phenomenon and interpret it in light of the findings.

Study setting: The research was conducted at a residential care center for older adults in Oran Province, Algeria.

Study sample: The scale was administered to a purposive sample of 30 older adults.

Study Instrument

The study used the Psychological Depression Scale for Older Adults developed by Nabil Mohamed El-Fahl (2016). The instrument comprises 80 items across 16 dimensions, with five items in each dimension.

Statistical Methods

The following statistical methods were used:

- Arithmetic means and standard deviations to examine the levels of the dimensions studied.
- One-way analysis of variance (ANOVA) to examine differences across more than two groups.

4. Presentation and Analysis of Results

Results Related to the Exploratory Question

To answer the question, “What is the level of depression among older adults?”, the following procedure was used.

The observed mean of the overall variable and each of its dimensions was compared with a hypothetical (theoretical) mean.

For example, the sadness dimension contains five items. Multiplying the number of items by 2 gives a hypothetical mean of 10.

The hypothetical mean for each remaining dimension was calculated in the same way, taking its number of items into account. The findings are presented below.

Table 05. Arithmetic Means and Standard Deviations for the Scale Dimensions

Scale dimension	Items	Observed mean	Hypothetical mean	Rank
Sadness	5	10.9000	10.00	9
Guilt	5	11.5667	10.00	4
Suicidal tendencies	5	10.7333	10.00	11
Sleep disturbances	5	10.7000	10.00	12
Slowing of daily life	5	10.5333	10.00	14
Psychological disturbance	5	12.2667	10.00	1
Sexual disturbance	5	11.4333	10.00	5
Psychological energy	5	10.6000	10.00	13
Hypochondriasis	5	10.8000	10.00	10
Weight and appetite loss	5	11.3667	10.00	7
Loss of the ability to make decisions	5	11.4000	10.00	6
Feeling of exhaustion	5	10.2333	10.00	16
Pessimism	5	11.5667	10.00	3
Feelings of failure	5	10.9667	10.00	8
Dissatisfaction	5	10.4000	10.00	15
Self-criticism	5	11.7000	10.00	2
Overall depression	**80**	**174.37**	**160**	**—**

The table shows that the level of depression among the older adults was high, because the observed mean of every dimension was higher than the hypothetical mean. Psychological disturbance ranked first (M = 12.26), followed by self-criticism (M = 11.70). Pessimism ranked third (M = 11.56), followed by guilt in fourth place (M = 11.56). Sexual disturbance came next (M = 11.43). The feeling of exhaustion ranked last (M = 10.23). The means for these dimensions and indicators were described as being within the moderate range. Together, however, they produced a high overall level of depression. The total observed mean was 174.37, compared with a hypothetical mean of 160.

Examination of Differences in Depression Levels According to Age

Table 08. Differences in Depression Levels According to Age

Measure	Source of variance	Sum of squares	Mean square	F-value	df	p-value
Depression	Between groups	1010.776	336.925	0.8190	3	0.495
Depression	Within groups	10696.190	411.392	0.8190	26	0.495
Depression	Total	11706.967		0.8190	29	0.495

The table examines differences in depression levels by age. The calculated F-value was 0.819, with a reported significance level of 0.459. This exceeds the threshold of 0.05. The study therefore retained the null hypothesis and rejected the research hypothesis. It concluded that depression levels did not differ significantly according to age.

Discussion

The study identified depressive manifestations among the older adults in the sample. After administering the depression scale of Nabil Mohamed El-Fadl and analyzing the data, psychological disturbance ranked first. It was followed by self-criticism, pessimism, guilt, sexual disturbance, loss of the ability to make decisions, weight and appetite loss, feelings of failure, sadness, and hypochondriasis.

These clinical symptoms constitute the distinctive presentation of depressive manifestations in older adults. This presentation is related to the developmental characteristics of old age and to the effects of aging on psychological balance and general adjustment. Self-criticism, pessimism, and guilt were particularly evident in the study sample. These experiences can be understood in relation to changes in older adults' professional, social, family, psychological, and emotional lives. Their subjective psychological experience therefore affects depressive manifestations. The clinical picture may nevertheless resemble that seen in adults. The psychosocial history of the older person must also be considered, as indicated by Dolores P. and Tannis A. (2000) and Michel (2010).

These factors contribute not only to the lived experience of aging but also to the development of psychological plasticity. This may help older adults deal with everyday difficulties associated with old age. These same factors may also contribute to clinical difficulties during this stage (Philippe et al., 2000).

According to Baltes (1987), gains and losses are part of development throughout life. As people grow older, however, losses may become more prominent than gains. This imbalance can reduce their capacity for adjustment.

Many difficulties experienced by older adults are not caused by primary aging alone. Other factors include trauma, illness, the underuse of abilities, and trials of life. Adults with emotional stability may retain an appropriate level of psychological well-being without experiencing depression, regardless of their surrounding circumstances.

Depression levels were high in the present sample. This may reflect psychological distress or vulnerability that makes adjustment to later life more difficult. Nevertheless, individual case assessment remains necessary. Evaluating depression in older adults is not an easy task because the manifestations may be unclear. Clinical specialists report that somatic symptoms often come to the fore, along with sleep disturbances and loss of appetite. A further difficulty is that depressive symptoms may resemble signs of normal aging or accompany cognitive difficulties and medical problems (Philippe Cappeliez et al., 2000, pp. 25–26).

Psychological assessment should therefore be accompanied by medical examination to rule out physical health problems. This can help the clinical psychologist plan appropriate care for older adults.

Depressive difficulties in later life are complex. Although depression is often viewed as a common problem at this stage, older adults face several challenges, particularly experiences of loss. Depressive symptoms may be less

explicit and may differ from those observed earlier in life. Depression may be associated with losses in several domains. These losses can affect narcissistic aspects of the self and reactivate feelings of failure linked to the depressive position.

From this perspective, depression in older adults may indicate difficulty carrying out the work of mourning for what they once were, as well as fear of what may happen in the future (René Roussillon et al., 2018, pp. 352–353).

Conclusion

Mood disorders are among the most common and most complex disorders in old age. Their complexity is related to the problem of co-occurring conditions. As A. Weil Barais notes, the assessment and diagnosis of psychological tension in the psychopathology of aging are difficult. Somatic and psychological processes overlap, and tension may also coexist with other psychological disorders or physical illnesses.

Clinical manifestations of psychological tension may mask depression. Examples include fear of being alone accompanied by stubbornness and behaviors described as hysterical in character (A. Weil Barais, 2008, pp. 102–103).

Advancing age provides a basis for the emergence of psychological tension and several forms of stress. These can, in turn, contribute to psychological disorders (A. Weil Barais, 2008, p. 95).

Identifying depression in older adults is therefore very difficult. This is linked to the somatic changes associated with aging, as noted above. Reduced pleasure occurs naturally in old age, while sadness alone is not regarded as an indicator of depression. Emotional changes are common among older adults. These may result from biological aging or from symptoms of physical illness associated with this stage of life.

The symptoms observed in depressed adults may also appear in older adults. However, older adults may not accept this condition. It is therefore necessary to look for symptoms they do not express directly. These include loss of interest, fatigue or psychological weakness, loss of energy, reduced appetite, and psychomotor slowing.

Depressive manifestations in later life are not specific to a single pattern. Somatic complaints may express the painful experience of depression and are more frequent among older adults than among adults. Cognitive complaints can also conceal depression. They may also mark the onset of a neurodegenerative condition. Depressive conditions in older adults are therefore characterized by their clinical diversity (Michel B., 2022).

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